

# TURAS - REFERRAL FORM



In order to provide you with the best service, referral information will be shared within Turas Counselling Services. This is to ensure your needs are met within the most appropriate service. If you have any concerns, or would like to discuss your needs further please contact Turas on the numbers overleaf.

<b>Name:</b>		<b>D.O.B &amp; Age:</b>	<b>Gender:</b>
<b>Referral Date:</b>		<b>PPS NO:</b>	<b>Referral Source:</b>
<b>Address &amp; contact details:</b>	Address:		
	Mobile:	Landline:	
Email:			
Is it ok for us to communicate with you about appointments using text messaging? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, please advise the best means of contact:			
<b>Reason for referral:</b>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit drugs <input type="checkbox"/> Licit drugs <input type="checkbox"/> Other problem		
	How long has drinking and/or drug use been a problem (weeks/months/years): ----- -----		
<b>Services sought:</b>	<input type="checkbox"/> Counselling <input type="checkbox"/> Community Alcohol Detox* <input type="checkbox"/> Outreach Support <input type="checkbox"/> Structured Day Programme <input type="checkbox"/> Six Week Motivational Programme <input type="checkbox"/> Men's Smart Recovery Group		
	What would you like to get from this service: ----- -----		
*If self-referral/agency referral for community alcohol detox (CAD) – a referral is also required from the individuals GP. Turas can instigate this process but require the individuals GP details.			
Are you registered with a GP? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please provide details)			
GP Name:			
Address and phone contact:			
Please list any medications and reasons for taking them:			

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Does the Individual/Service user give consent for Turas to contact and share information with their GP as part of the CAD assessment?

Yes     No    Individuals signature:

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If you are under 18 is your parent/guardian aware you are making this self-referral:     Yes  
 No

Other Agency support:

Address:

Phone:

**Referrer details:** (if you are completing this form for yourself you don't need to fill in this section)

Agency:

Address:

Named person and contact details:

Is the Individual/Service User aware of the referral:     Yes     No

If the referral is for a young person aged 14-18  
has parental consent be obtained:     Yes     No

If no, please advise why this is the case:

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Are there any risks that we should be aware of?     Yes     No

If yes please provide details (e.g. alcohol/substance related, mental health, suicide/self-harm, risk from others, child protection)

Can we use your premises to conduct appointments with this person?     Yes     No

Would you like feedback on the outcome of this referral?     Yes     No

How did you hear about the service?

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Please send this referral form to:

A: Turas Counselling Services Ltd, 59 Clanbrassil Street, Dundalk, Co Louth

E: [info@turascounselling.ie](mailto:info@turascounselling.ie) , T: 042 933 8221/4 , F: 042 933 8225

W: [www.turascounselling.ie](http://www.turascounselling.ie)

